International Health Systems

Source: http://www.pnhp.org/facts/international_health_systems.php?page=all

Health care systems in the Organization for Economic Cooperation and Development (OECD) countries primarily reflect three types of programs:

1. In a single-payer national health insurance system, as demonstrated by Canada, Denmark, Norway, and Sweden, health insurance is publicly administered and most physicians are in private practice.
2. Great Britain and Spain are among the OECD countries with national health services, in which salaried physicians predominate and hospitals are publicly owned and operated.
3. Highly regulated, universal, multi-payer health insurance systems are illustrated by countries like Germany and France, which have universal health insurance via sickness funds. The sickness funds pay physicians and hospitals uniform rates that are negotiated annually (also known as an "all-payer" system).

The OECD regularly publishes a CD-ROM with 10+ years of comparative data for those interested in pursuing further research. It is available on the OECD website at www.oecd.org.

Snapshots of health systems in 16 countries

This publication covers the organization and financing of the health systems,and the provision of and developments in health care in each country. Edited by Susanne Grosse-Tebbe and Josep Figueras, the state of affairs is presented for Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Israel, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom.
Please click on the link below to read the article

http://www.euro.who.int/document/e85400.pdf

Australia

Australia's population size of 19 million people is roughly the same as that of Texas. Its infant mortality rate is 5 per 1,000 live births, and life expectancy at birth is 75.9 years for men and 81.5 years for women. In 1941, the beginnings of Australia's universal health care system emerged. Australia spends 8.5% of its GDP on health care, and its 1998 per capita expense was $2,043-US.

The government administers the compulsory national health insurance program (Medicare). National health insurance is funded by a mixture of general tax revenue, a 1.5% levy on taxable income (which accounts for 18.5% of federal outlays on health),

state revenue, and fees paid by patients. The government funds 68% of health expenditures (45% federal and 23% state) and has control over hospital benefits, pharmaceuticals, and medical services. States are charged with operating public hospitals and regulating all hospitals, nursing homes, and community based general services. Additionally, the states pay for the public hospitals with federal government assistance negotiated via five yearly agreements. Mainly not-for-profit mutual insurers (private insurance) cover the gap between Medicare benefits and schedule fees for inpatient services. Private insurance covers 1/3 of the population and accounts for 11% of health expenditures.

Patients are free to choose their GP. Primary care physicians act as gatekeepers, and physicians are generally reimbursed by a fee-for-service system. The government sets the fee schedules, but physicians are free to charge above the scheduled fee or they may directly bill the government when there is no patient charge. Prescription pharmaceuticals have a patient co-payment, and out-of-pocket payments account for 19% of health expenditures. Physicians in public outpatient hospitals are either salaried or paid on a per-session basis.

Austria

Austria is home to 7.6 million people, approximately the same number that live in North Carolina. The country has universal access to health care through a compulsory system of social insurance. A system of private insurance also exists. About 8.2% of Austria's GDP is spent on health care, and the 1998 per capita expense was $1,968-US.

Private doctors with contracts to the social insurance funds are paid on a fee-for-service system with expenditure limits based on the case and per doctor per pay period. Hospital physicians are salaried. Approximately 50% of the health expenditures are funded by progressive payroll taxes, 25% are financed by non-specific taxes, and the rest is funded directly out-of-pocket or through private insurance companies. The contributions to the health insurance funds (payroll taxes) are split between employers and employees on a parity basis.

Patients are free to choose their physicians, as long as the physician has a contract with the insurer. Benefits and prices of services are fixed in agreements between representatives of the insured and representatives of the providers. All medical and nursing education is free. The infant mortality rate in Austria is 4.9 per 1,000 live births, and life expectancy at birth is at 74.7 years for men and 80.9 years for women.

Belgium

Belgium is home to about 10.2 million people, almost the same number of people who live in the state of Ohio. Its infant mortality rate is 6 per 1,000 live births, and its life expectancy at birth is 74.8 years for men and 81.1 years for women. Today, Belgium spends 8.8% of its GDP on health care, and the 1998 per capita expense was $2,081-US.

The health care system is funded primarily through sickness funds. Belgium's health insurance program operates at four distinct levels: the central government, national associations, federations of local societies, and local mutual aid societies. The general attitude in Belgium is that the pluralism of the health insurance system stimulates each local fund to work hard to attract and satisfy its members.

Patients have their free choice of any doctor. Primary care physicians are paid via fee-for-service, directly from the patient, or partially reimbursed, except with low-income patients who are exempt from pay. They are reimbursed with a negotiated fee, but extra billing is allowed. Specialists are paid via fee-for-service and are not restricted to hospitals.

Canada

Canada's population size of 30.5 million people is roughly the same as that of California. Its infant mortality rate is 5.5 per 1,000 live births, and its life expectancy at birth is 75.8 years for men and 81.4 years for women. National health insurance had been discussed in Canada at the federal level since 1919, but no real action was taken until 1944. Today, Canada's health system is characterized by single-payer national health insurance, and the federal government requires that insurance cover "all medically necessary services." Canada spends 9.5% of GDP towards health care, and the 1998 per capita expense was $2,312-US.

National health insurance (Medicare) is a public program administered by the provinces and overseen by the federal government. Medicare is funded by general tax revenues. Federal contributions are tied to population and provincial economic conditions, and provinces pay the remainder. Medicare accounts for 72% of health expenditures. In addition, the majority of Canadians have supplemental private insurance coverage through group plans, which extends the range of insured services, such as dental care, rehabilitation, prescription drugs, and private care nursing. The private sector (private insurance and out-of-pocket payments) accounts for 28% of health expenditures.

Most physicians in Canada are in private practice and accept fee-for-service Medicare payment rates set by the government. Provincial medical associations negotiate insured fee-for-service schedules with provincial health ministries. Some physicians set their own rates but are not reimbursed by the public system. Hospitals are mainly non-profit and operate under global institution-specific or regional budgets with some fee-for-service payment. Less than 5% of all Canadian hospitals are privately owned.

The Cochrane Collaboration is a Canadian non-profit clearinghouse for studies in clinical epidemiology.It is based at McMaster University and compiles systematic reviews of the effects of health care interventions. It also hosts annual conferences for researchers. The Cochrane Library is at http://cochrane.mcmaster.ca.

Cuba

Cuba has a population of 11,236,000 which is about the same as Ohio. The life expectancy is 74.7 for males and 79.2 for females in 2001 compared to 74.3 for males and 79.5 for females in the U.S. The infant mortality rate is 7 per 1,000 live births. Cuba's universal health system began in 1959 with the change of government. Cuba spends 6.3 percent of it GDP on healthcare, and its 1997 per capita expense was $131-USD. Despite Cuba's low spending, it was ranked 39th for "overall health system performance" by the World Health Organization, compared to the U.S. ranking of 37 (out of 191 countries).

Cuba has a national health service. Services are available without charge to everyone. They are provided by salaried personnel in facilities run by the government. Patients have access to 24-hour, neighborhood doctor and nurse teams (1 doctor-nurse team per 120-170 patients). If necessary, patients are referred to multi-specialty clinics ("polyclinics") and/or hospitals. A patient may change their GP to a doctor in another neighborhood. Physicians spend their mornings in their practice and their afternoons making house calls to the elderly and the infirm. Every patient is seen at least twice a year, either by coming into the clinic or by a house call from the physician.

The government pays for 89.2 percent of health expenditures. Benefits include full medical and dental services, as well as prescription drugs. Private out-of-pocket expenditures account for the remaining 10.8 percent of health expenditures. Because of the strict embargo, Cuba relies on donations of some medical supplies from Canada, Europe, Latin America, and U.S. NGOs. However, Cuba exports physicians to practice all over Central and South America, Africa, and Asia. Cuba also has established medical schools, staffed by Cuban professors, in Guyana, Benin, Uganda, Ghana, Yemen and Equatorial Guinea.

*Compiled by Jeanine Valrie, February 2004

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Finland

Finland has a population size of 5 million people, which is about the same number of people who live in the state of Maryland. Finland has an infant mortality rate of 4.2 per 1,000 live births and its life expectancy at birth is 73.5 years for men and 80.6 years for women. The country spends 6.9% of GDP on health care, and its 1998 per capita expense was $1,502-US. In 1964, national health insurance was enacted in Finland.

The Finnish health system is primarily funded (80%) by general tax revenues collected by the local and national governments. The basic administrative levels in Finland are divided into communes and municipalities. The local authorities in Finland number 445, averaging about 10,000 people each.

GP's practice mostly in health centers. They are salaried, but many are paid fee-for-service for overtime. Hospital physicians, who must be specialists, are salaried.

Denmark

Denmark, a small country, is home to 5.3 million people - the same number as in the state of Wisconsin. Its infant mortality rate is 4.7 per 1,000 live births, and its life expectancy at birth is 73.7 years for men and 78.6 years for women. Denmark has had a single-payer national health system since 1961. Approximately 8.3% of GDP is spent on health care, and the 1998 per capita expense was $2,133-US.

The Danish health care system is funded by progressive income taxes, and is publicly administered. Hospitals are run by the 14 counties and the City of Copenhagen. Physicians who work with the hospitals receive salaries, which are determined by negotiation between government and doctor's unions. GP's are 40% per capita fee, and 60% fee-for-service. Specialists are mostly fee-for-service. All medical and nursing education is free.

There is strong incentive for patients to choose a GP in their immediate area of residence. GP's will then make referrals to specialists. There are no co-pays for physician or hospital care, but patients do pay a share of drug costs - usually between 25 and 50%. Private insurance, held by approximately 27% of the population, is used mainly for medications and dental expenses.

France

France has a population close to that of the entire Midwest - 60.9 million people. France has an infant mortality rate of 4.7 per 1,000 live births and a life expectancy at birth of 74.6 years for men and 82.2 years for women. The country has had a national health insurance system since 1928, but universal coverage did not occur until 1978. Approximately 9.6% of France's GDP is spent on health care, and its 1998 per capita expense was $2,077-US.

The French health care system is primarily funded by Sickness Insurance Funds (SIF's), which are autonomous, not-for-profit, government-regulated bodies with national headquarters and regional networks. They are financed by compulsory payroll contributions (13% of wage), of employers (70% of contributions) and employees (30% of contributions). SIF's cover 99% of the population and account for 75% of health expenditures. The 3 main SIF's

(CNAMTS, MSA, and CANAM) cover about 95% of the population, and the remaining 5% of the insured population are covered under 11 smaller schemes. The remainder of health expenditures is covered by the central government, by patients' out-of-pocket payments, and by Mutual Insurance Funds (MIF's), which provide supplemental and voluntary private insurance to cover cost-sharing arrangements and extra billings. MIF's cover 80% of the population and account for 6% of health expenditures. The major public authority in the French health system is the Ministry of Health. Below this are 21 regional health offices that regulate each of the 95 provinces.

Patients are free to choose their providers and have no limits on the number of services covered. GP's have no formal gatekeeper function. Private physicians are paid on a fee-for-service basis and patients subsequently receive partial or full reimbursement from their health insurance funds. The average charge for an office visit to a GP and a specialist are $18 and $25, respectively. Private hospitals are profit-making and non-profit making, usually with fee-for-service physicians. Public hospitals employ salaried physicians, who make up 1/3 of all GP's in France. All medical and nursing education is free.

Germany

Germany is home to approximately 82 million people, nearly 1/3 of the U.S. population. Germany's infant mortality rate is 4.7 per 1,000 live births, and its life expectancy at birth is 74.5 years for men and 80.5 years for women. In 1883, Germany was the first country to establish the foundations of a national health insurance system and has since gradually expanded coverage to over 92% of the population. Today, Germany spends 10.6% of its GDP on health care, and the 1998 per capita expense was $2,424-US.

Everyone in Germany is eligible for health insurance, and individuals above a determined income level have the right to obtain private coverage. The German health care system is predominantly characterized by Sickness Insurance Funds (SIF's), which are funded by compulsory payroll contributions (14% of wage), equally shared by employers and employees. SIF's cover 92% of the population and account for 81% of health expenditures. The rest of the population (the affluent, self-employed, and civil servants) is covered by private insurance, which is based on voluntary, individual contributions. Private insurance accounts for 8% of health expenditures.

GP's have no formal gatekeeper function. Private physicians, over half of which are specialists, are paid on a fee-for-service basis. Representatives of the sickness funds negotiate with the regional associations of physicians to determine aggregate payments.

Physicians who work in hospitals are full-time salaried specialists, whose work is entirely devoted to in-patients. All medical and nursing education is free.

Japan

Japan has a population of 122 million people, nearly half that of the United States. The infant mortality rate in Japan is 3.6 per 1,000 live births, and life expectancy at birth is at 77.2 years for men and 84 years for women. Approximately 7.6% of GDP is spent on health care, and the 1998 per capita expense was $1,822-US. Japan's current system of universal health care was initiated in 1958.

The Employee's Health Insurance System is financed by compulsory payroll contributions (8% of wage), equally shared by employers and employees, and covers employees and their dependents. The National Health Insurance System covers the self-employed, pensioners, their dependents, and members of the same occupation. The local governments act as insurers, and premiums are calculated on the basis of income, the number of individuals in the insured household, and assets. Premiums account for 57% of health expenditures. The federal government contributes 24% to medical care expenditures and local governments contribute 7%.

About 80% of hospitals and 94% of private clinics are privately owned and operated. While some public not-for-profit hospitals exist, investor-owned for-profit hospitals are prohibited in Japan. Patients are free to choose their ambulatory care physicians, who are reimbursed on the basis of a negotiated, uniform fee-for-service schedule. Physicians have no formal gatekeeper function. Due to the combination of medical and pharmaceutical practices a large part of a physician's income is derived from prescriptions. Hospital physicians have fixed salaries.

The Netherlands

The Netherlands has a population of 15.8 million, which is approximately the same number of people who live in the state of Florida. In 1997, 72% of the population had government-assured health insurance coverage. The infant mortality rate is 5.2 per 1,000 live births and life expectancy is at 75.2 years for men and 80.7 years for men. The Netherlands spend 8.6% of its GDP on health care, and the 1998 per capita expense was $2,070-US.

The health care system in the Netherlands is very similar to that in Belgium; health care is primarily financed by employer-employee social insurance. Health care is provided by private not-for-profit institutions, and the compulsory health insurance system is financed through sickness funds. 70% of the population is in the public health care system. 30% of the population (mostly civil servants and high-income groups) has private insurance, because they are not eligible for social health insurance. There are currently plans to convert the entire system to a tax-based one.

Most primary care physicians are in a solo office practice (54%) or practice in small groups. Reimbursement is by capitation for "public patients" (2/3) and via fee-for-service (1/3). Specialists are salaried and are restricted to hospitals.

New Zealand

New Zealand has a population size close to that of Atlanta, Georgia - 3.5 million people. In 1941, it achieved universal coverage and was the first country with a free-market economy to do so. Radical health sector restructuring occurred in 1993, which introduced a set of market-oriented ideas. However, the new system performed poorly and was thus restructured 3 years later. Today, New Zealand spends 8.1% of its GDP on health care and the 1998 per capita expense was $1,424-U.S. The infant mortality rate is 6.8 per 1,000 live births and life expectancy is at 75.2 years for women and 80.4 years for men.

The health system is funded through taxation and administered by a national purchasing agent, the Health Funding Authority (HFA). Health care is provided by 23 hospital provider organizations (Hospital and Health Services), GP's (most of whom are grouped as Independent Practitioner Associations, IPA's), and other noncrown providers of child care, disability support services, etc. These parties compete for the provision of health services. Public funding accounts for 76% of health expenditures. Complementary, non-profit, private insurance, on the other hand, covers about 1/3 of the population and accounts for 7% of health expenditures. It is most commonly used to cover cost-sharing requirements, elective surgery in private hospitals, and specialist outpatient consultations. New Zealand's government is a purchaser and provider of health care and retains the responsibility for legislation and general policy matters.

Health care is free for children, and all patients have their free choice of GP. Out-of-pocket payments account for 17% of health expenditures. GP's act as gatekeepers and are independent, self-employed providers. They are paid via fee-for-service, partial government subsidy, and negotiated contracts with HFA through IPA's. The payment system is currently moving from fee-for-service to capitation. Private insurance and out-of-pocket contributions pay the remainder. Hospitals are mostly semiautonomous, government-owned companies that contract with the HFA. Specialists are commonly salaried, but may supplement their salaries through treatment of private patients.

Norway

Norway is home to approximately 4.4 million people, about the same number that live in Washington DC. Norway has had a single-payer national health insurance system since 1966. The National Insurance Act guaranteed citizens universal access to all forms of medical care. Norway's health system is funded by progressive income tax, and from block grants from central government, with 8.9% of GDP being spent on health care, and in 1998 the per capita expense was $2,425-US.

Patients are free to choose their own physician and hospital, however, registration with local GP's who act as gatekeeper, will begin in 2001. Patients are responsible for co-pays for some physician visits, approximately $15. Patients are also responsible for co-pays for prescription drugs, up to $216 per year. Once that level of expense has been reached, prescription drugs are covered at 100%. All hospital care is covered at 100%.

Hospital physicians have fixed salaries. GP's have either fixed salaries or fee-for-service agreements. All medical and nursing education is free. The infant mortality rate in Norway is 4 per 1,000 live births, and life expectancy at birth is at 75.5 years for men and 81.3 years for women.

Spain

Spain's population size is close to that of Texas and New York combined - about 39.1 million people. The country has had a comprehensive, single-payer national health service since 1978. The Constitution of 1978 explicitly affirms everyone's right to health care. Spain spends 7.1% of its GDP on health care, and its 1998 per capita expense was $1,218-US.

The Spanish health care system is funded by payroll taxes through the National Institute of Health program (INSALUD), which in 1984 was 75% financed by employers and 25% financed by employees. Those with higher incomes have the option of obtaining private medical care. Public hospitals are run by one of the provinces or municipalities. The INSALUD program operates a large network of hospitals and ambulatory care clinics. Hospital physicians are on full-time salaries.

All medical and nursing education is free. The infant mortality rate in Spain is 5 per 1,000 live births, and its life expectancy at birth is 74.8 years for men and 82.2 years for women.

South Africa

South Africa's population is 43,791,000 (for comparison, that's about 10 million more people than live in the state of California). Since 1994, South Africa has been trying to reverse the social effects of apartheid. South Africa's infant mortality rate is 59 per 1,000 live births. Men have a life expectancy at birth 47.7 years, for women it is 50.3 years. South Africa spends 7.1 per cent of its GDP on health and its 1997 per capita expense was $268-USD.

South Africa's health system consists of a large, under-resourced public sector (serving 80 percent of population) and a small private sector for high income earners (18 percent of the population). Primary health care is free to everyone but highly specialized services are available in the private sector to those who can afford it. The government contributes about 42 percent of all expenditures on health. The remaining 58 percent of health expenditure is paid by private sources in insurance premiums and out-of-pocket payments.

Because of problems in South Africa's healthcare system, there is a shortage of medical professionals. High levels of emigration of medical professionals to other countries drain South Africa's resources. Newly graduating South African doctors and pharmacists must now complete a year of compulsory community service in understaffed hospitals and clinics. Most South Africans see inexpensive, traditional herbal medicine healers before seeking treatment from a physician. These traditional healers carry out more than 80 percent of the country's medical consultations.

In spite of the addition of the "right to healthcare" in their post-apartheid 1996 constitution, South Africa's health care system continues to face problems of heavy reliance on out-of-pocket payments and an uneven distribution of facilities and personnel, all of which lead to inadequate and unequal access to health services

*Compiled by Jeanine Valrie, February 2004

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Sweden

Sweden has a population close to that of New York City - 8.8 million people. The country has an infant mortality rate of 3.6 per 1,000 live births and a life expectancy at birth of 76.9 years for men and 81.9 years for women. Sweden spends 8.4% of its GDP on health care, the 1998 per capita expense was $1,746. Sweden has had its current universal health care system since 1962. Tuition for medical and nursing education is free, and students generally take loans for living expenses of around $9,000-US per year.

The Swedish health care system is financed by both incomes and patient fees. County councils own and operate hospitals, employ physicians and run the majority of general

practices and outpatient facilities. Other physicians work in private practice and are paid by the counties on a fee-for-service basis.

Co-pays, which were mandated in 1970, are capped, with limits on how much a person is required to contribute annually. For example, patients over age 16 pay $9 per day for hospitalization. The maximum individual expense for hospital and physician services is approximately $108 per year. The maximum individual expense for prescription drugs is $156 per year. Once these sums are met, care is covered at 100%.

Taiwan

Taiwan enacted its single-payer national health insurance program in 1995; in all estimates, it has been very successful. Taiwan enacted the program (from multiple insurance companies, like the United States) to the single-payer system with no measurable increase in costs, while insuring more than 8 million Taiwanese citizens who previously lacked insurance. While utilization did increase, its costs were largely offset by the enormous savings under single-payer. Taiwan also did not report any increase in queues or waits for services.

The United Kingdom

Britain has a population size of 57 million, nearly three times the number of people in Texas. The infant mortality rate in the United Kingdom is 5.7 per 1,000 live births, and life expectancy at birth is 74.6 years for men and 79.7 years for women. Britain has had a National Health Service (NHS) since 1948. 6.7% of GDP goes towards health expenditures, and the 1998 per capita expense was $1,461-US.

The British government is a purchaser and provider of health care and retains responsibility for legislation and general policy matters. The government decides on an annual budget for the NHS, which is administered by the NHS executive, regional, and district health authorities. The NHS is funded by general taxation and national insurance contributions and accounts for 88% of health expenditures. Complementary private insurance, which involves both for-profit and not-for-profit insurers, covers 12% of the population and accounts for 4% of health expenditures.

Physicians are paid directly by the government via salary, capitation, and fee-for-service. GP’s act as gatekeepers. Private providers set their own fee-for-service rates but are not generally reimbursed by the public system. Specialists may supplement their salary by treating private patients. Hospitals are mainly semi-autonomous, self-governing public trusts that contract with groups of purchasers on a long-term basis.

The British government this year has announced a huge funding increase for the NHS. Specifically, it will receive 6.2% more in funding every year until 2004. Current plans to improve the system over the next five years include hiring 7,500 more specialists, 2,000 GP’s and 20,000 nurses; providing 7,000 more acute beds in existing hospitals and building 100 new hospitals by 2010; demanding that GPs see a patient within 48 hours

of an appointment; and finally, guaranteeing that patients wait no more than three months for their first outpatient appointment with a specialist and no more than six months after that appointment for an operation.

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